### Title

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### Journal

Health promotion practice, 21(1)

### ISSN

1524-8399



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### Publication Date

2020

### DOI

10.1177/1524839919884912

Peer reviewed

*Invited Commentary*

# *Cultural Competence or Cultural Humility? Moving Beyond the Debate*

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***Keywords:*** *cultural humility; cultural competence; health disparities; health education*

When public health physician Melanie Tervalon and health educator and clinic administrator Jane Murray-Garcia introduced the concept of cultural humility to the fields of medicine and public health over 30 years ago, they catalyzed fascinating and continuing discourse on whether cultural humility is, in fact, more important than working to become "competent" in the cultures of those with whom we work and interact (Tervalon & Murray-Garcia, 1998). They defined cultural humility as "a lifelong commitment to self-evaluation and critique, to redressing power imbalances . . . and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (p. 123). Furthermore, Tervalon and Murray-Garcia stressed that "culture" should not be limited to dimensions like racial or ethnic identity,but should include, for example, the culture of the physician or public health professional, which also requires humility in dealing with patients, families, and communities.

The concept of cultural humility caught fire in fields including medicine, nursing, public health, community psychology, and social work. Indeed, by 2019, Tervalon and Murray-Garcia's (1998) original article alone had been cited in over 1,500 peer reviewed articles. A wealth of tools including cultural humility trainings, curricula, and a 2012 videotape by health education professor Vivian Chavez (2012) also emerged and remain frequently used in educating both current practitioners and the next generation of professionals in health promotion and related fields.

Yet the earlier concept of cultural competence continues to have a far larger following. Selig, Tropiano, and Greene-Moton (2006) quoted a landmark definition from the U.S. Department of Health & Human Services Health Resources & Services Administration (original source no longer online):

> Cultural competence comprises behaviors, attitudes, and policies that can come together on a continuum that will ensure that a system, agency, program, or individual can function effectively and appropriately in diverse cultural interaction and settings. It ensures an understanding, appreciation, and respect of cultural differences and similarities within, among and between groups. (p. 249S)

Developed by social workers and counseling psychologists in the early 1980s (Gallegos, 1982; Nadan, 2017), cultural competence soon became ubiquitous in the health and health care services literature as well, particularly following strong and early support for its importance from leading institutions like the Institute of Medicine (IOM) in two landmark books, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (IOM, 2003a) and *Who Will Keep the Public Healthy?* (IOM, 2003b). Major health philanthropies, including the

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**Health Promotion Practice**
Month XXXX Vol. XX, No. (X) 1–4
DOI: 10.1177/1524839919884912
Article reuse guidelines: sagepub.com/journals-permissions

Robert Wood Johnson Foundation (McGee-Avila, 2018) and the W. K. Kellogg Foundation, and large medical institutions, led by Kaiser Permanente, also took up the call, with Kaiser's Institute for Culturally Competent Care (Chong, 2002) quickly heralded as a national model.

In our personal lives and in our work with communities, health professionals, and students in public health and health care, we see substantial complementarity and synergy between the concepts and practice of cultural humility and cultural competence. We now briefly describe the continuing controversy over the merits of the two concepts and make the case for ending the debate and instead embracing a both/and approach as critical to our thinking, our practice and our lives in communities and societies that are increasingly diverse along multiple dimensions.

## WHY THE CONTROVERSY?

As noted earlier, when the concept of cultural competence gained widespread attention in public health and medicine in the 1980s and 1990s, it quickly landed an important place in health promotion and health education practice. Kaiser Permanente's Institute for Culturally Competent Care created and widely distributed easily accessed manuals on culturally competent care with and for use by health professionals with five diverse racial/ethnic and other groups (e.g., lesbian, gay, bisexual, and transgender populations; people with disabilities). Trainings in cultural competence and special sessions at the annual meetings of organizations, including the Society for Public Health Education and the American Public Health Association, were among the many ways in which concept dissemination and implementation spread.

Within academic public health, the first university class in this area "Cultural Competence to Eliminate Health Disparities," was offered in 2002 in the University of Michigan, Flint's Department of Public Health and Health Education (Selig et al., 2006), and soon was being offered three times per year to a total of 200 students annually. The course quickly became required for all undergraduate and graduate public health students, including those in premed and health administration, and remains a popular elective, as well, for students in biology, social work, and other fields (S. Selig, personal communication, May 19, 2019). The University of Michigan Flint course was followed by numerous others, as well as modules and intensive trainings in public health and medical schools, nursing, and ancillary health and social professions across and beyond the United States. Thousands of articles, book chapters, and Web resources on cultural competence in health promotion and related fields also were, and continue to be, developed to serve a wide range of stakeholders. For example, the Office of Minority Health (see https://minorityhealth.hhs.gov/) has been providing online education in cultural competence through the *Think Cultural Health* initiative since 2004, offering courses and continuing education for a variety of professions. The courses are free and include content designed for (1) disaster and emergency personnel, (2) nurses, (3) oral health professionals, (4) physicians, nurse practitioners, and physician assistants, (5) *promotores de salud*, and—new in 2019—(6) behavioral health professionals (U.S. Department of Health and Human Services, Office of Minority Health, 2019).

Yet, despite its wide dissemination and use in education and practice, the notion of cultural competence has continued to cause some uneasiness, in part because of the growing understanding that we cannot ever be truly *competent* in another's culture (Chavez, 2018; Isaacson, 2014; Minkler, Pies, & Hyde, 2012; Murray-Garcia & Tervalon, 2014), making the term itself misleading. The word "competence" also was described as problematic by some individuals and communities for whom it implies a top-down approach, with one entity (often including some highly educated and privileged members of a given racial or other group) deciding what content should be included and which benchmarks or criteria should be used to assess competence for their group(s). Cultural competence also is described by some as too binary a construct, implying that if one is not culturally competent, he or she is implicitly *incompetent*, and perhaps not equipped to interact professionally with members of particular groups (Chavez, 2012, 2018).

As illustrated above, however, many describe cultural competence in extremely positive terms, with the IOM naming it one of eight new content areas (along with informatics and genomics) in which all schools of public health should be offering training (IOM, 2003b). Furthermore, scholars have argued that the more nuanced understanding of culturally competent public health professionals can itself contribute to individual and community control over and participation in decision making (Cerezo, Galceran, Soriano, & Moral, 2014; Taylor-Ritzler et al., 2008). Finally, in his recent and in-depth reflective analysis of the concepts of cultural humility and cultural competence, Danso (2018) argues that cultural competence already incorporates the concept of cultural humility, stressing as it does "the need to question one's assumptions, beliefs and biases," and other tenets at the heart of cultural humility and antioppressive practice such as "respect for difference, reducing power differentials, building partnerships, and learning from clients" (Danso, 2018, p. 415; see also Ben-Ari & Strier, 2010).

In our view, and as Isaacson (2014) and others note as well, *cultural competence* is not something we

achieve or fail to achieve but rather a reminder to continue to strive to know more about communities of all types with which we work or interact. Together with the concept and embodied practice of deep *cultural humility*, it provides health educators and other public health professionals with some of our most important tools in working with diverse individuals, groups, and communities in today's complex world. Below we provide examples from our own lives and/or public health practice, in which the need for both cultural competence and cultural humility was powerfully experienced.

## ELLA GREENE-MOTON

As a community leader and longtime partner in public health, who is also an African American woman, my personal struggle with the notion of cultural competence *or* cultural humility stems from the constant pushback from many of my academic partners on the subject. Too often, academics (and especially those from the dominant culture) have embraced cultural humility as the more important and contemporary of the two concepts—as if a choice must be made between them. Yet for many community members and partners, and particularly those who are people of color, perceptions that academics, regardless of race/ethnicity or other identities, often fail to take the time up front to really learn about the cultural realities of groups with whom they will be working sometimes has caused misunderstandings and distrust, holding partnerships back from reaching their full potential. Because of such experiences, I firmly believe that cultural humility/cultural competence is not an either/or but rather a both/and. I accept cultural humility to be the ability to maintain an interpersonal stance that is other-oriented (or open to others) while accepting cultural competence as the ability to interact effectively with people of different cultures—more of a learned/taught condition. I pride myself on being able to claim both—competence and humility—recognizing both as a lifelong journey, without an end point. I believe cultural humility is a spiritual attribute, drawing from the ability to be humble and couched in a state of selflessness, while cultural competence hinges on a deliberate engagement in cultural knowledge transfer.

## MEREDITH MINKLER

As a White woman and longtime professor and community-engaged researcher and activist, my need for both cultural competence and cultural humility—and the broader understanding of culture that both terms suggest—was epitomized recently in a gathering of thousands of public health professionals. As is my habit, when asked to stand for the national anthem, I "took a knee," in symbolic protest of the inequitable treatment of Black and Brown people in our criminal justice system and society at large. Two military officers, both African American and one in dreadlocks, stood beside me, and I assumed, naively, that they'd join me and others in making this gesture. But when they both stood ramrod straight, hands over their hearts, I realized that my lack of both cultural competence and cultural humility had caused me to misread this situation completely. Having more *cultural humility*, for example, would have helped me recognize immediately my own biases and stereotypic beliefs, for example, that being a Black man (and especially one wearing dreadlocks) would trump being a member of the military in a situation like this one. But my lack of *cultural competence*—in part, *about* the military—compounded my ignorance and prejudices.

When later that day I met with a small and diverse group of young public health professionals, I related this story and was immediately set straight. One of the women explained that she, too, was in the military, and in her experience getting on your knees (even when getting up from push-ups!) conveyed weakness. Another remarked that in her Baptist community, kneeling is a sign of deference to God. And a Muslim woman commented that in her faith, getting on one's knees was a sign of humility, and thus may have been appropriate in this context—but she was not sure. In short, my gesture of solidarity with Black and Brown people too often denied justice at the hands of the law was seen in very different ways by this small group. It was a reminder of how much I need to learn about many cultures, including military culture. And while I continue to "take a knee" when the national anthem is played, I no longer presume to know how this gesture is being interpreted by others.

## SUMMARY

In sum, and particularly in the troubling contexts of our time characterized by increasingly virulent racism and a weakening of civil and human rights both nationally and globally, we believe it imperative to find a road around the false choice between cultural humility and cultural competence. As we have argued, both concepts grew out of increasing recognition of the need for public health, medical, social work, and other professionals to reflect on and address our own biases and actively seek to understand and address the cultural or social realities of the diverse individuals, groups, and communities with whom we and our groups and organizations interact.

Furthermore, and while typically focused on building understanding and bridging differences based on race/ethnicity, both cultural humility and cultural competence

also have been profitably used to encourage self-reflection and reflective practice with respect to ability/disability, sexual orientation and gender identity, and numerous other dimensions too often characterized by inequitable power, privilege, and injustice that affect health and well-being. Both concepts increasingly have stressed the need to challenge the institutions and systems in which we live and work that may, wittingly or unwittingly, enable these injustices to remain. Finally, as we pursue the path of "both/and," we can more effectively partner across a wide range of barriers and divides to work collectively toward racial, social, and health equity and the more just and habitable society and planet on which our work and our future depend.

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